Agency:	**107 Health Care Authority**
Decision Package Code/Title:	**ML2-EB Improve Post ACA Eligible Response**
Budget Period:	**2015-17 Biennial Submittal**
Budget Level:	**ML2 – Maintenance Level 2**

Recommendation Summary Text

The Health Care Authority is requesting increased resources in the amount of 37.5 FTEs and $6,746,000 ($1,822,000 GF-State) in the 2015-17 biennium for the Medicaid Eligibility Determination Services (MEDS) activities that support client access to health care coverage.

Package Description

The successful implementation of the Affordable Care Act (ACA) in Washington State resulted in the enrollment of over 372,000 new Medicaid and CHIP clients in just nine months, about 177percent of forecasted enrollment. The accelerated rate of enrollment has created a critical need for additional resources to meet the resulting workload. Timely resolution of eligibility-related issues for clients is crucial to their ability to access health care coverage. The HCA is seeking more, sustained FTE resources to meet the workload demands created from the Medicaid expansion that started January 2014. The ACA has substantial requirements and the corresponding workload that was unanticipated, and needs immediate attention.

The HealthPlanFinder (HPF) system used to determine eligibility does not have several elements incorporated into the system to correctly determine eligibility, thereby creating work for MEDS staff that was expected to be done through the HPF. The original allocation of FTEs given to the MEDS section was based on the HPF being an error-proof system and an expectation that all staff would work post enrollment cases when they were not assisting with phone calls or in-person requests. Since the system doesn't work as anticipated and multiple complicated workloads have resulted, the associated workloads are ongoing and do not have an anticipated system fix any time in the near future. Many of the workloads will always exist.

Additional FTEs are necessary to meet workload demands of a client population of over 1.2 million. The enrolled client population has far exceeded enrollment expectations that had not been anticipated to be achieved within the first several years, much less the first ten months of operation. All FTE requests are for work that is continuous and not time limited.

Original FTE allocations were based on data estimated from a joint agency workgroup back in mid-2012. The workgroup included the HCA, the Department of Social and Health Services (DSHS), the Office of Financial Management (OFM), the Health Benefits Exchange (HBE), and the Governor's office. The numbers enrolled in Modified Adjusted Gross Income (MAGI) Medicaid programs has far exceeded the original anticipated enrollment from the joint agency workgroup. Enrollment has surpassed goals that were not expected to be achieved until 2018.

The FTE request and specific workload association are outlined below:

Medical Assistance Specialist (MAS) 3 – 32.3 FTEs estimated

- Presumptive Eligibility - this is a new workload that has become the responsibility of the MEDS section. It is a federal requirement to provide presumptive eligibility;

- Pends and Errors - cases processed through the HPF will often hit errors (also known as edits) causing cases to be pended in the HPF system. The MAGI cases require staff from the MEDS section to review and manually complete processing of the case;
- Immigration Reports - the field to identify immigration status in the HPF is not functional, causing staff to review each case manually;
- Medicare cases – staff must manually end coverage for existing clients who become Medicare eligible during their certification period;
- Refugee, homeless teens, out of state clients – staff must manually ensure correct eligibility is provided or discontinued;
- Department of Corrections (DOC) cases - the DOC and the HCA have collaborated to ensure that prisoners about to be released become enrolled in coverage at the time of release, ensuring their current medical needs are met and necessary medications are available;
- Spend down – for cases requiring a medical spend down, the case must be manually processed;
- Merges and Splits – in cases where the identification numbers from the Automated Client Eligibility System (ACES), the ProviderOne system, and/or the HPF do not cross reference appropriately, they must be manually corrected.

Medical Assistance Specialist 4 – 2.6 FTEs estimated – lead workers for the additional MAS 3 FTEs described above (ratio of 1:12).

Medical Assistance Specialist 5 – 2.6 FTEs estimated – to supervise the additional staff (ratio of 1:13).

Questions related to this request should be directed to Marcia Wendling at (360) 725-1836 or at Marcia.Wendling@hca.wa.gov.

Fiscal Detail/Objects of Expenditure

	FY 2016	FY 2017	Total
1. Operating Expenditures:			
Fund 001-1 GF-State	$ 951,000	$ 871,000	$ 1,822,000
Fund 001-C GF-Federal Medicaid Title XIX	$ 2,570,000	$ 2,354,000	$ 4,924,000
Total	**$ 3,521,000**	**$ 3,225,000**	**$ 6,746,000**

	FY 2016	FY 2017	Total
2. Staffing:			
Total FTEs	37.5	37.5	37.5

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3. Objects of Expenditure:	**FY 2016**	**FY 2017**	**Total**
A - Salaries And Wages	$ 1,674,000	$ 1,674,000	$ 3,348,000
B - Employee Benefits	$ 592,000	$ 592,000	$ 1,184,000
C - Personal Service Contracts	$ -	$ -	$ -
E - Goods And Services	$ 951,000	$ 951,000	$ 1,902,000
G - Travel	$ 8,000	$ 8,000	$ 16,000
J - Capital Outlays	$ 296,000	$ -	$ 296,000
N - Grants, Benefits & Client Services	$ -	$ -	$ -
Other (specify) -	$ -	$ -	$ -
Total	**$ 3,521,000**	**$ 3,225,000**	**$ 6,746,000**

4. Revenue:	**FY 2016**	**FY 2017**	**Total**
Fund 001-C GF-Federal Medicaid Title XIX	$ 2,570,000	$ 2,354,000	$ 4,924,000
Total	**$ 2,570,000**	**$ 2,354,000**	**$ 4,924,000**

Narrative Justification and Impact Statement

What specific performance outcomes does the agency expect?

Approval of this funding request will allow timely resolution of the workloads identified, as defined by federal or state guidelines. Funding approval will reduce paying managed care premiums when coverage could be ended, allow clients to begin receiving services when they apply and are determined eligible through the HPF, and reduce constituent calls to legislators and the Governor's office.

Performance Measure Detail

Activity Inventory

H002 HCA Direct Operations

Is this decision package essential to implement a strategy identified in the agency's strategic plan?

The mission of the HCA is to provide high quality health care for the state's most vulnerable residents. One of the HCA's key metrics is implementation of Health Care Reform through the ACA. Medicaid expansion and the new MAGI eligibility standards provide health coverage to low income individuals that currently have no access to affordable health care.

Does this decision package provide essential support to one or more of the Governor's Results Washington priorities?

This request meets the Governor's health care priority of "Continue to enroll families in affordable insurance plans and Apple Health". The MEDS section is operationally responsible for Apple Health eligibility and post enrollment. The MEDS section needs the resources identified in order to enroll and maintain enrollment of children, adults and families in Apple Health according to federal guidelines.

This request additionally meets the Governor's health care priority of "Engage communities in identifying local health problems and assist them in bringing all state and local resources to bear on them". We have placed the MEDS staff in facilities across the state to now assist clients, families, stakeholders, clinics, hospitals, and others with the MAGI eligibility and enrollment questions. Having the MEDS staff on-site in each county in the state to assist with this priority is a tremendous benefit to our communities.

What are the other important connections or impacts related to this proposal?
The services provided through this request are essential to the success of the ACA in our state. The Legislature, stakeholders and the public have a vested interest in ensuring that residents of Washington State receive the medical coverage to which they are entitled to and receive the services directly associated with that coverage. Risks to the state include the potential loss of federal funding by missing mandated deadlines and the financial costs of eligibility determination errors. Washington has worked closely with a vast array of stakeholders statewide to enroll eligible residents so they can receive coverage not previously offered. Delay of enrollment has the potential to create negative health outcomes for otherwise eligible clients.

What alternatives were explored by the agency, and why was this alternative chosen?
The MEDS section added 30 non-permanent MAS 3 staff in March 2014 to assist with high inventories created from the October 2013 implementation of the ACA and ongoing workload due to previously noted system issues. The employment of 20 of these staff will end on September 30, 2014 and 10 will end on February 28, 2015. The MEDS section also received temporary assistance in processing workloads from areas outside the MEDS section such as the Medical Assistance Customer Service Center, Authorization Services Office, Claims Processing and Foster Care staff.

The MEDS section has employed several Lean practices, including staff focus groups to modify work flows, staffing models, processes and procedures, and creating documented efficiencies from these efforts.

What are the consequences of adopting this package?
The consequences are all positive as it allows the workload created through the ACA to be processed timely and with less risk to funding and taxpayer dollars. Ensuring correct enrollment upfront lessens the potential of clients being enrolled or denied incorrectly and mitigates legal risks.

What is the relationship, if any, to the state capital budget?
None

What changes would be required to existing statutes, rules, or contracts, in to implement the change?
None

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Expenditure and Revenue Calculations and Assumptions

Revenue Calculations and Assumptions:
Revenue is based on anticipated enhanced federal Medicaid matching for eligible work and is estimate to cover 73 percent of the costs identified.

Expenditure Calculations and Assumptions:
Costs are estimated for staff and related cost based on agency averages. Additional funding is requested to cover increases in translation costs for letters to clients due to unsupported language translation requirements and for the increase in the toll-free line usage.

Translation costs are estimated using the following assumptions:

- One percent of the MAGI population, or 9,500 clients, will require translation;
- Two mailings per year will be needed, one at $15 per letter and one at $30 per letter;
- There is $69,000 in the base level of funding.

9,500 clients X $15 letter = $142,500
9,500 clients X $30 letter = $285,000
Less $69,000 in the base
Total increased costs = $359,000 (rounded to thousands)

Toll-free line costs are estimated using the following assumptions:

- $2,617 is the average monthly cost for the first four months of fiscal year 2014;
- $18,827 is the average monthly cost for the last four months of fiscal year 2014;
- $16,210 is the difference between the two;
- $49,000 (rounded to thousands) is the annualized amount.

Which costs, savings, and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?
Distinction between one-time and ongoing costs:
One-time costs are needed for the workstation establishment and needed equipment for the identified positons. All other costs are assumed to be on-going.

Budget impacts in future biennia:
With the exception of workstation establishment, all costs will continue into future biennia.

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